Senate

General Assembly

File No. 132

February Session, 2004

Substitute Senate Bill No. 141

Senate, March 18, 2004

The Committee on Program Review and Investigations reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAL MALPRACTICE INSURANCE RATES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 52-192a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) After commencement of any civil action based upon contract or seeking the recovery of money damages, whether or not other relief is sought, the plaintiff may, subject to the provisions of subsection (b) of this section and not later than thirty days before trial, file with the clerk of the court a written "offer of judgment" signed by the plaintiff or the plaintiff's attorney, directed to the defendant or the defendant's attorney, offering to settle the claim underlying the action and to stipulate to a judgment for a sum certain.

(b) At least sixty days before filing an offer of judgment pursuant to

subsection (a) of this section in an action for medical malpractice, the plaintiff or the plaintiff's attorney shall provide the defendant or defendants in such action with (1) written authorizations, in a form that complies with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, for the release of all medical records of all health care providers rendering care and treatment for the plaintiff's injuries, including all medical records of all health care providers that rendered care and treatment to the plaintiff prior to and after the date of the plaintiff's personal injuries for any conditions that were similar or related to such injuries, and (2) the names of all persons who will give expert testimony on behalf of the plaintiff concerning the prevailing professional standard of care for a health care provider.

(c) The plaintiff shall give notice of the offer of **[**settlement**]** judgment to the defendant's attorney or, if the defendant is not represented by an attorney, to the defendant himself or herself. Within sixty days after being notified of the filing of the "offer of judgment" and prior to the rendering of a verdict by the jury or an award by the court, the defendant or the defendant's attorney may file with the clerk of the court a written "acceptance of offer of judgment" agreeing to a stipulation for judgment as contained in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter judgment immediately on the stipulation. If the "offer of judgment" is not accepted within sixty days and prior to the rendering of a verdict by the jury or an award by the court, the "offer of judgment" shall be considered rejected and not subject to acceptance unless refiled. Any such "offer of judgment" and any "acceptance of offer of judgment" shall be included by the clerk in the record of the case.

[(b)**]** (d) After trial, the court shall examine the record to determine whether the plaintiff made an "offer of judgment" which the defendant failed to accept. If the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's "offer of judgment", the court shall add to the amount so recovered twelve per cent annual interest on said amount,

[computed from the date such offer was filed in actions commenced before October 1, 1981. In those actions commenced on or after October 1, 1981, the**]** with respect to an offer of judgment filed prior to the effective date of this section, and interest at an annual rate of two percentage points above the weekly average five-year constant maturity yield of United States Treasury securities, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the beginning of each year for which interest is owed, with respect to an offer of judgment filed on or after the effective date of this section. The interest shall be computed from the date the complaint in the civil action was filed with the court if the "offer of judgment" was filed not later than eighteen months from the filing of such complaint. If such offer was filed later than eighteen months from the date of filing of the complaint, the interest shall be computed from the date the "offer of judgment" was filed. The court may award reasonable attorney's fees in an amount not to exceed three hundred fifty dollars, and shall render judgment accordingly. This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action.

Sec. 2. Section 52-190a of the general statutes, as amended by section 14 of public act 03-202, is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to actions filed on or after said date*):

(a) No civil action shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint or initial pleading shall contain a certificate of the attorney or party filing the action that such reasonable inquiry gave rise to a good faith belief that grounds

exist for an action against each named defendant. [For the purposes of this section, such good faith may be shown to exist if the claimant or his attorney has received a written opinion, which shall not be subject to discovery by any party except for questioning the validity of the certificate,] To show the existence of such good faith, the claimant or the claimant's attorney shall obtain a written opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence. Such written opinion shall set forth the name and qualifications of, and be signed by, such similar health care provider. The claimant or the claimant's attorney shall attach such written opinion to such certificate. The court, upon the filing of the complaint or initial pleading with such certificate and written opinion, shall seal such written opinion and, not later than thirty days thereafter, determine if the health care provider who signed the written opinion qualifies as a similar health care provider, as defined in section 52-184c. If the court determines that the health care provider who signed the written opinion does not qualify as a similar health care provider, as defined in section 52-184c, it shall notify the claimant or the claimant's attorney and permit the claimant or the claimant's attorney to submit another written opinion not later than thirty days after receipt of such notice. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney submitted the certificate.

(b) Upon petition to the clerk of the court where the action will be filed, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by subsection (a) of this section. This period shall be in addition to other tolling periods.

Sec. 3. (NEW) (*Effective from passage*) (a) At least thirty days prior to filing a civil action to recover damages resulting from personal injury or wrongful death, whether in tort or contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, the claimant shall send a written notice to such health care provider that contains a brief description of the claim and a certificate of good faith as provided in section 52-190a of the general statutes, as amended by this act. The sending of such notice shall toll the statute of limitations applicable to such action until thirty days after the date such notice was sent or, if a request for mediation is made pursuant to subsection (b) of this section, until thirty days after the date such mediation is completed. This tolling period shall be in addition to other tolling periods.

(b) Not later than thirty days after the sending of such notice to such health care provider, either the claimant or the health care provider may contact the Office of the Chief Court Administrator to request non-binding, pre-suit mediation. If any party to the proposed action requests mediation, all parties shall participate in the mediation.

(c) The Chief Court Administrator may assign a judge of the Superior Court to act as a mediator in the matter or assign two attorneys admitted to practice in this state, one whose practice consists primarily of representing plaintiffs in medical malpractice actions and one whose practice consists primarily of representing defendants in medical malpractice actions, to act as mediators in such matter. Any attorney admitted to practice in this state who is willing and able to act as a mediator may submit his or her name to the Chief Court Administrator for approval and placement on a list of available mediators developed by said administrator. Attorneys who act as

mediators shall serve without compensation.

(d) Upon the written request of any party to a mediation, the other party shall, not later than thirty days after the receipt of such request, provide copies of any relevant medical records to such requesting party.

(e) The mediation process under this section shall be deemed to be settlement negotiations for evidentiary and confidentiality purposes. Any findings or recommendations of the mediator or mediators shall be confidential and not admissible in any court proceedings.

(f) The mediation process under this section shall be completed not later than one hundred twenty days after the request for mediation is made pursuant to subsection (b) of this section. The mediator or mediators shall provide written notice to the parties of the completion of the mediation for purposes of computing the applicable limitations period.

Sec. 4. Section 52-251c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) In any claim or civil action to recover damages resulting from personal injury, wrongful death or damage to property occurring on or after October 1, 1987, the attorney and the claimant may provide by contract, which contract shall comply with all applicable provisions of the rules of professional conduct governing attorneys adopted by the judges of the Superior Court, that the fee for the attorney shall be paid contingent upon, and as a percentage of: (1) Damages awarded and received by the claimant; or (2) settlement amount pursuant to a settlement agreement.

(b) In any such contingency fee arrangement such fee shall be the exclusive method for payment of the attorney by the claimant and shall not exceed an amount equal to a percentage of the damages awarded and received by the claimant or of the settlement amount received by the claimant as follows: (1) Thirty-three and one-third per

cent of the first three hundred thousand dollars; (2) twenty-five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars.

(c) The provisions of subsection (b) of this section are intended to protect the general rights of the public and may not be waived by the claimant.

[(c)**]** (d) For the purposes of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant, except that in a civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365; "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement, except that in a claim or civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365; and "fee" shall not include disbursements or costs incurred in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense.

Sec. 5. (*Effective from passage*) (a) There is established a task force on medical malpractice litigation alternatives to examine the feasibility of developing systemic alternatives to the current personal injury litigation system for medical malpractice claims. Such examination shall include, but not be limited to, consideration of an enterprise liability system and a no-fault system for resolving medical malpractice claims.

(b) The task force shall be composed of the following members: The Commissioner of Public Health, or said commissioner's designee; the Insurance Commissioner, or said commissioner's designee; one judge

with experience sitting on personal injury trials, to be appointed by the speaker of the House of Representatives; one person with experience in alternative dispute resolution mechanisms, to be appointed by the president pro tempore of the Senate; one law professor with experience teaching tort law, to be appointed by the minority leader of the House of Representatives; one law professor with experience teaching health care law, to be appointed by the minority leader of the Senate; one attorney with experience representing plaintiffs in personal injury litigation, to be appointed by the cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to the judiciary; one attorney with experience representing defendants in personal injury litigation, to be appointed by the ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to the judiciary; one representative of the insurance industry with experience writing medical malpractice insurance, to be appointed by the cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to insurance; one actuary with experience in medical malpractice insurance, to be appointed by the ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance; one representative of a trade organization representing physicians, to be appointed by the cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health; one representative of a trade organization representing hospitals, to be appointed by the ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health; and two members of the public who have been involved in medical malpractice litigation, to be appointed by the Governor.

(c) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president

pro tempore of the Senate shall select the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force which shall be held no later than sixty days after the effective date of this section.

(e) Not later than January 5, 2005, the task force shall report its findings and recommendations, including any proposals for legislative changes, to the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary, public health and insurance, in accordance with section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 5, 2005, whichever is earlier.

Sec. 6. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with respect to workers' compensation and employers' liability insurance and certain professional liability insurance, on or before the effective date **[**thereof, every**]** of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, **[**every**]** each manual of classifications, rules and rates, and **[**every**]** each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing as described in subsection (a) of this section for

workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) (A) Each filing as described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals or advanced practice registered nurses shall be subject to approval in accordance with subsection (a) of this section except that if the commissioner determines the market for such insurance is not competitive in accordance with subparagraph (D) of this subdivision or if the insurer or rating organization requests a rate increase or decrease of fifteen per cent or more the filing shall be subject to prior rate approval in accordance with this subsection. At the time the insurer or rating organization files a proposed rate increase during a noncompetitive market, the insurer shall notify each insured subject to the rate increase that such increase has been requested. The notice shall state the percentage by which the insured's current premium will

increase if the filing is approved.

(B) For any filing subject to prior rate approval pursuant to this subsection the commissioner shall notify the public of the filing by submitting notice for publication in the Connecticut Law Journal not later than five business days after the date of filing. The notice shall indicate that the commissioner shall accept public comment for thirty days after the date the notice is published.

(C) The filing shall be deemed approved sixty days after the date the notice is published unless (i) an insured or the insured's representative requests a hearing not later than forty-five days after the date the notice is published, (ii) the commissioner determines to hold a hearing on the filing without such a request, or (iii) if no hearing is held, the commissioner disapproves the filing. Any rate filing for which a public hearing has been held shall be deemed approved not later than one hundred eighty days after the date the rate was filed unless the commissioner disapproves the filing. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner.

(D) Not later than October 1, 2004, and annually thereafter, the commissioner shall determine if a competitive market exists for professional liability insurance for physicians and surgeons, hospitals or advanced practice registered nurses. Such determination shall apply to each rate filed on or after January first of the next succeeding year. In making such determination, the commissioner shall consider relevant tests of competition pertaining to market structure, market performance and the degree of competition in the market. Such tests may include, but are not limited to, (i) the size and number of insurers actively engaged in the market, both in general and by physician specialty, (ii) whether there are enough insurers to provide options to insureds, (iii) the degree of market concentration and changes in market concentration over time, (iv) the extent to which any insurer or group controls all or a significant portion of the market, (v) the ease of entry into the market, and (vi) underwriting restrictions. The

commissioner may amend the determination of whether a competitive market exists if the commissioner finds that the market has changed significantly since the prior determination.

(E) Any determination of the commissioner made pursuant to this subdivision shall be subject to review as provided in section 38a-19.

(c) The form of any insurance policy or contract the rates for which are subject to the provisions of sections 38a-663 to 38a-696, inclusive, other than fidelity, surety or guaranty bonds, and the form of any endorsement modifying such insurance policy or contract, shall be filed with the Insurance Commissioner prior to its issuance. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policy or contract. If at any time the commissioner finds that any such policy, contract or endorsement is not in accordance with such provisions or any other provision of law, the commissioner shall issue an order disapproving the issuance of such form and stating the reasons for disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

Sec. 7. (NEW) (*Effective from passage*) The Insurance Commissioner shall maintain a database containing information about the competitiveness of the market for professional liability insurance for medical professionals and entities. Such database shall be based, in part, on the data collected pursuant to section 38a-676 of the general statutes, as amended by this act, including, but not limited to, the rates by physician specialty and the number of physicians insured under alternative risk mechanisms. The commissioner may consider any relevant information collected by any other agency of this state that would assist in determining the degree of competition that exists and how medical professionals and entities are insured.

Sec. 8. (NEW) (*Effective October 1, 2004*) (a) On and after October 1, 2004, no captive insurer, as defined in section 38a-91 of the general statutes, may insure a health care provider or entity in this state against liability for medical malpractice unless the captive insurer has

obtained a certificate of authority from the Insurance Commissioner, except that no certificate of authority shall be required for any captive insurer that is duly licensed in this state to offer such insurance.

(b) Any captive insurer seeking to obtain a certificate of authority shall make application to the commissioner, on such form as the commissioner requires, setting forth the line or lines of business which it is seeking authorization to write. The captive insurer shall file with the commissioner a certified copy of its charter or articles of association and evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, a statement of its financial condition in such form as is required by the commissioner, together with such evidence of its correctness as the commissioner requires and evidence of good management in such form as is required by the commissioner. The captive insurer shall submit evidence of its ability to provide continuous and timely claims settlement. If the information furnished is satisfactory to the commissioner, and if all other requirements of law have been complied with, the commissioner may issue to such insurer a certificate of authority permitting it to do business in this state. Each such certificate of authority shall expire on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as required by the commissioner. Failure of a captive insurer to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause for revocation of the insurer's authority to write those lines of business.

(c) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority shall submit and the requirements with which it shall comply.

(d) The commissioner may, at any time, for cause, suspend, revoke or refuse to renew any such certificate of authority or in lieu of or in addition to suspension or revocation of such certificate of authority the

commissioner, after reasonable notice to and hearing of any holder of such certificate of authority, may impose a fine not to exceed ten thousand dollars. Such hearings may be held by the commissioner or any person designated by the commissioner. Whenever a person other than the commissioner acts as the hearing officer, the person shall submit to the commissioner a memorandum of findings and recommendations upon which the commissioner may base a decision. The commissioner may, if the commissioner deems it in the interest of the public, publish in one or more newspapers of the state a statement that, under the provisions of this section, the commissioner has suspended or revoked the certificate of authority of any captive insurer to do business in this state.

(e) Each application for a certificate of authority shall be accompanied by a nonrefundable fee as set forth in section 38a-11 of the general statutes, as amended by this act. All expenses incurred by the commissioner in connection with proceedings under this section shall be paid by the person filing the application.

(f) Any captive insurer aggrieved by the action of the commissioner in revoking, suspending or refusing to renew a certificate of authority or in imposing a fine may appeal therefrom, in accordance with the provisions of section 4-183 of the general statutes, except venue for such appeal shall be in the judicial district of New Britain. Appeals under this section shall be privileged in respect to the order of trial assignment.

Sec. 9. Subsection (a) of section 38a-11 of the general statutes, as amended by section 10 of public act 03-152 and section 9 of public act 03-169, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, one hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, twenty-five dollars; (3) for filing all documents prerequisite to the issuance of a license to an

insurance company, one hundred seventy-five dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand one hundred dollars; (4) for filing any additional paper required by law, fifteen dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, twenty dollars; (6) for each certified copy of a license to a company, twenty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, twenty dollars; (8) for amending a certificate of authority, one hundred dollars; (9) for each license issued to a rating organization, one hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of twenty-five dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of twenty-five dollars for each request for any agent appointment; (B) a fee of forty dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of twenty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company; (12) with respect to insurance producers: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued; and (C) a fee of forty dollars for each license renewed; (13) with respect to public adjusters: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; and (B) a fee of one hundred twenty-five dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of ten dollars for each examination taken, except when a testing service is

used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of forty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of forty dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of thirteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of thirteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred dollars for each license issued; and (C) a fee of one hundred twenty-five dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; and (B) a fee of five hundred dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of forty dollars for each license issued or renewed; (19) a fee of thirteen dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, twenty-five dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, five dollars; (C) for filing the annual report, ten

dollars; and (D) for filing any additional paper required by law, three dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, four dollars; (B) for each certified copy of permit, two dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, four dollars; (22) with respect to reinsurance intermediaries: A fee of five hundred dollars for each license issued or renewed; (23) with respect to viatical settlement providers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (24) with respect to viatical settlement brokers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (25) with respect to viatical settlement investment agents: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (26) with respect to preferred provider networks, a fee of two thousand five hundred dollars for each license issued or renewed; (27) with respect to rental companies, as defined in section 38a-799, a fee of forty dollars for each permit issued or renewed; (28) with respect to a certificate of authority for a captive insurer pursuant to section 8 of this act, a fee of one hundred seventy-five dollars for each certificate issued or renewed; and **[**(28)**]** (29) with respect to each duplicate license issued a fee of twenty-five dollars for each license issued.

Sec. 10. Section 19a-17a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Upon entry of any medical malpractice award or upon entering a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall notify the Department of Public Health of the terms of the award or settlement and shall provide to the department a copy of the award or settlement and the underlying complaint and answer, if any. The

department shall review all medical malpractice awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. On and after December 31, 2004, such review shall be conducted in accordance with written guidelines developed by the department, in accordance with section 20-13b, as amended by this act, to determine the basis for such further investigation or disciplinary action. Any document received pursuant to this section shall not be considered a petition and shall not be subject to the provisions of section 1-210, as amended, unless the department determines, following completion of its review, that further investigation or disciplinary action is warranted.

Sec. 11. Section 20-8a of the general statutes is amended by adding subsection (k) as follows (*Effective from passage*):

(NEW) (k) The board shall review each recommendation of a finding of no probable cause made by the department pursuant to section 20-13e, as amended by this act. The board shall examine the petition and the entire record of the investigation and may request the department for more information or for a reconsideration of such finding. If no action is taken by the board within ninety days of the submission to the board of such recommendation, such finding of no probable cause shall be considered a final decision by the board.

Sec. 12. Section 20-13b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health, with advice and assistance from the board, may establish such regulations in accordance with chapter 54 as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive, as amended by this act. On or before December 31, 2004, such regulations shall include, but need not be limited to: (1) Guidelines for screening petitions received to determine which petitions will be investigated; (2) a prioritization system for the conduct of investigations to ensure prompt action when it appears necessary; (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient

records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations and additional interviews of patients and peers; and (4) a list of factors the department may use to identify physicians who may not be performing effectively and should be the subject of further investigation by the board, including, but not limited to, (A) health status or age, (B) number of complaints and malpractice claims, settlements or judgments, (C) frequent changes in location, (D) changes in area of practice, (E) adverse actions by professional organizations, managed care organizations or licensing boards, (F) failure to recertify in a board specialty, (G) inability to obtain liability insurance in the regular insurance market, and (H) unavailability of peer review. In no event shall any one factor alone cause the department to institute an investigation.

Sec. 13. Section 20-13i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The department shall file with the Governor and the joint standing committee on public health of the General Assembly on or before January 1, 1986, and thereafter on or before January first of each succeeding year, a report of the activities of the department and the board conducted pursuant to sections 20-13d and 20-13e, as amended by this act. Each such report shall include, but shall not be limited to, the following information: The number of petitions received; the number of petitions not investigated, and the reasons why; the number of hearings held on such petitions; the outcome of such hearings; the timeliness of action taken on petitions; the number of notifications received pursuant to section 19a-17a, as amended by this act; the number of such notifications with no further action taken, and the reasons why; the outcomes for notifications where further action is taken and, without identifying the particular physician concerned, a brief description of the impairment alleged in each such petition or notification and the actions taken with regard to each such petition or notification by the department and the board.

Sec. 14. (*Effective from passage*) (a) There is established a task force to assist the Medical Examining Board in developing disciplinary guidelines for use in the physician disciplinary process. The guidelines shall include, but need not be limited to: (1) Identification of each type of violation; (2) a minimum and maximum penalty for each type of violation; (3) additional optional conditions that may be imposed by the board for each violation; (4) identification of factors the board shall consider in determining if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that, when a deviation from the guidelines occurs, the reason for the deviation shall be identified by the board. The guidelines shall also contain a provision that, in each final action in the disciplinary process, the board shall provide evidence of how it applied the guidelines.

(b) The task force shall consist of the following members:

(1) Four licensed physicians, one of whom shall be a member of the Medical Examining Board, to be appointed one each by the speaker of the House of Representatives, the president pro tempore of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate;

(2) Four members of the public who have been involved in medical malpractice litigation, to be appointed one each by the speaker of the House of Representatives, the president pro tempore of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate;

(3) One attorney with experience representing plaintiffs in personal injury litigation, to be appointed by the cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to the judiciary;

(4) One attorney with experience representing defendants in personal injury litigation, to be appointed by the ranking members of

the joint standing committee of the General Assembly having cognizance of matters relating to the judiciary; and

(5) The Commissioner of Public Health, or the commissioner's designee.

(c) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force which shall be held no later than sixty days after the effective date of this section.

(e) Not later than January 5, 2005, the task force shall submit a report on the disciplinary guidelines to the joint standing committees of the General Assembly having cognizance of matters relating to public health, judiciary and insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 5, 2005, whichever is earlier.

Sec. 15. Subsection (a) of section 20-13e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of subdivision (10) of subsection (a) of section 19a-14, to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (e) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, as amended, at the conclusion

of such eighteen-month period. Any such investigation shall be confidential except as provided in subdivision (2) of this subsection, and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in a rehabilitation program in accordance with subsection (b) of this section and the physician agrees to participate in such program in accordance with terms agreed upon by the department and the physician. If at any time subsequent to the filing of a petition and during the eighteen-month period, the department **[**makes**]** recommends a finding of no probable cause and the Medical Examining Board accepts such recommendation, as provided in section 20-8a, as amended by this act, the petition and the entire record of such investigation shall remain confidential, except as provided in subdivision (2) of this subsection, unless the physician requests that such petition and record be open.

(2) In any investigation in which a review by a consultant has been obtained by the department, and the board has accepted the department's recommendation of a finding of no probable cause, the text of such review shall be available to the person who filed the petition, or to such person's legal representative. The identity of the consultant shall remain confidential.

(3) The department shall notify the person who filed the petition or such person's legal representative at such time as the board has accepted the department's recommendation of a finding of no probable cause, and include the reason for such finding and, if available, a consultant's review in accordance with subdivision (2) of this subsection.

Sec. 16. Subsection (b) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license to practice medicine, surgery, podiatry, chiropractic or natureopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address, the name of the insurance company providing such person's professional liability insurance and the policy number of such insurance, such person's area of specialization, whether such person is actively involved in patient care, and such other information as the department requests.

Sec. 17. (NEW) (*Effective from passage*) On or before January 1, 2005, and annually thereafter, the Department of Public Health shall report, in accordance with section 11-4a of the general statutes, the number of physicians by specialty who are actively providing patient care. On or before January 1, 2007, and every third year thereafter, the department shall report, in accordance with section 11-4a of the general statutes, an assessment of the inventory of practicing physicians. Such report shall include, but need not be limited to, (1) the number of physicians listed by specialty, (2) the number of physicians actively involved in patient care, (3) projections for physician employment, (4) identification of insufficient supply of certain specialists, and (5) identification of barriers to meeting needs for certain specialists.

Sec. 18. Section 19a-17a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Upon the filing in the Superior Court of any medical malpractice claim against any individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383, the clerk of the court in which such claim was filed shall, within thirty days after such filing, mail a copy of the complaint, indicating all such licensed persons named in such claim, to the Department of Public Health.

(b) Upon entry of any medical malpractice award or upon entering a settlement of a malpractice claim against an individual licensed

pursuant to chapter 370 to 373, inclusive, 379 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall notify the Department of Public Health of the terms of the award or settlement and shall provide to the department a copy of the award or settlement and the underlying complaint and answer, if any.

(c) The department shall review all claims and all medical malpractice awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. Any document received pursuant to this section shall not be considered a petition and shall not be subject to the provisions of section 1-210, as amended, unless the department determines, following completion of its review, that further investigation or disciplinary action is warranted.

Sec. 19. Section 20-13j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section: "Department" means the Department of Public Health, and "physician" means a physician licensed pursuant to this chapter.

(b) The department, after consultation with the Connecticut Medical Examining Board and the Connecticut State Medical Society shall collect the following information to create an individual profile on each physician for dissemination to the public:

(1) The name of the medical school attended by the physician and the date of graduation;

(2) The site, training, discipline and inclusive dates of the physician's postgraduate medical education required pursuant to the applicable licensure section of the general statutes;

(3) The area of the physician's practice specialty;

(4) The address of the physician's primary practice location or primary practice locations, if more than one;

(5) A list of languages, other than English, spoken at the physician's primary practice locations;

(6) An indication of any disciplinary action taken against the physician by the department or by the state board;

(7) Any current certifications issued to the physician by a specialty board of the American Board of Medical Specialties;

(8) The hospitals and nursing homes at which the physician has admitting privileges;

(9) Any appointments of the physician to Connecticut medical school faculties and an indication as to whether the physician has current responsibility for graduate medical education;

(10) A listing of the physician's publications in peer reviewed literature;

(11) A listing of the physician's professional services, activities and awards;

(12) Any hospital disciplinary actions against the physician that resulted, within the past ten years, in the termination or revocation of the physician's hospital privileges for a medical disciplinary cause or reason, or the resignation from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to medical competence in such hospital;

(13) A description of any criminal conviction of the physician for a felony within the last ten years. For the purposes of this subdivision, a physician shall be deemed to be convicted of a felony if the physician pleaded guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere; **[**and**]**

(14) To the extent available, and consistent with the provisions of

subsection (c) of this section, all medical malpractice court judgments and all medical malpractice arbitration awards against the physician in which a payment was awarded to a complaining party during the last ten years, and all settlements of medical malpractice claims against the physician in which a payment was made to a complaining party within the last ten years; and

(15) To the extent available, and consistent with the provisions of subsection (c) of this section, the information required under subdivisions (12), (13) and (14) of this subsection from any other state.

(c) Any report of a medical malpractice judgment or award against a physician made under subdivision (14) of subsection (b) of this section shall comply with the following: (1) Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement; (2) information concerning paid medical malpractice claims shall be placed in context by comparing an individual physician's medical malpractice judgments, awards and settlements to the experience of other physicians licensed in Connecticut who perform procedures and treat patients with a similar degree of risk; (3) all judgment award and settlement information reported shall be limited to amounts actually paid by or on behalf of the physician; and (4) comparisons of malpractice payment data shall be accompanied by (A) an explanation of the fact that physicians treating certain patients and performing certain procedures are more likely to be the subject of litigation than others and that the comparison given is for physicians who perform procedures and treat patients with a similar degree of risk; (B) a statement that the report reflects data for the last ten years and the recipient should take into account the number of years the physician has been in practice when considering the data; (C) an explanation that an incident giving rise to a malpractice claim may have occurred years before any payment was made due to the time lawsuits take to move through the legal system; (D) an explanation of the effect of treating high-risk patients on a physician's malpractice history; and (E) an explanation that malpractice cases may be settled for reasons other

than liability and that settlements are sometimes made by the insurer without the physician's consent. Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

(d) Pending malpractice claims against a physician and actual amounts paid by or on behalf of a physician in connection with a malpractice judgment, award or settlement shall not be disclosed by the department to the public. This subsection shall not be construed to prevent the department from investigating and disciplining a physician on the basis of medical malpractice claims that are pending.

(e) Prior to the initial release of a physician's profile to the public, the department shall provide the physician with a copy of the physician's profile. Additionally, any amendments or modifications to the profile that were not supplied by the physician or not generated by the department itself shall be provided to the physician for review prior to release to the public. A physician shall have sixty days from the date the department mails or delivers the prepublication copy to dispute the accuracy of any information that the department proposes to include in such profile and to submit a written statement setting forth the basis for such dispute. If a physician does not notify the department that the physician disputes the accuracy of such information within such sixty-day period, the department shall make the profile available to the public and the physician shall be deemed to have approved the profile and all information contained therein. If a physician notifies the department that the physician disputes the accuracy of such information in accordance with this subsection, the physician's profile shall be released to the public without the disputed information, but with a statement to the effect that information in the identified category is currently the subject of a dispute and is therefore not currently available. Not later than thirty days after the

department's receipt of notice of a dispute, the department shall review any information submitted by the physician in support of such dispute and determine whether to amend the information contained in the profile. In the event that the department determines not to amend the disputed information, the disputed information shall be included in the profile with a statement that such information is disputed by the physician.

(f) A physician may elect to have the physician's profile omit information provided pursuant to subdivisions (9) to (11), inclusive, of subsection (b) of this section. In collecting information for such profiles and in the dissemination of such profiles, the department shall inform physicians that they may choose not to provide the information described in said subdivisions (9) to (11), inclusive.

(g) Each profile created pursuant to this section shall include the following statement: "This profile contains information that may be used as a starting point in evaluating the physician. This profile should not, however, be your sole basis for selecting a physician."

(h) The department shall maintain a web site on the Internet for use by the public in obtaining profiles of physicians.

(i) No state law that would otherwise prohibit, limit or penalize disclosure of information about a physician shall apply to disclosure of information required by this section.

(j) All information provided by a physician pursuant to this section shall be subject to the penalties of false statement, pursuant to section 53a-157b.

(k) A physician shall notify the department of any changes to the information required in subdivisions (3), (4), (5), (7), (8) and (13) of subsection (b) of this section not later than sixty days after such change.

(l) The department shall regularly update physician profiles by consulting the National Practitioner Data Bank for information on out-

of-state medical malpractice court judgments, arbitration awards and settlements, and adverse actions taken in other states against a licensed physician. The department shall regularly compare information in the physician profiles with information in the National Practitioner Data Bank for consistency and accuracy.

Sec. 20. (NEW) (*Effective October 1, 2004*) (a) As used in this section: (1) "Licensee" means a physician licensed pursuant to chapter 370 of the general statutes; and (2) "department" means the Department of Public Health; and (3) "registration period" means the twelve-month period that commences on the date of renewal of the licensee's license, as provided in section 19a-88 of the general statutes, as amended by this act.

(b) Each licensee shall complete a minimum of forty hours of continuing education within two registration periods. The continuing education shall be in areas related to the licensee's practice and shall consist of courses approved by the Department of Public Health.

(c) Each licensee shall obtain a certificate of completion from the provider of the continuing education for all continuing education hours that are successfully completed and shall retain such certificate for a minimum of six years following the license renewal date for which the activity satisfies the continuing education requirement. Upon request by the department, the licensee shall submit the certificate to the department.

(d) A licensee who fails to comply with the provisions of this section shall be subject to disciplinary action pursuant to section 20-13c of the general statutes.

(e) The provisions of subsection (b) of this section shall not apply to a licensee (1) during the two years immediately following the date on which the licensee's license is renewed for the first time; or (2) who has been continuously licensed since October 1, 1979, and is not currently involved in direct patient care. The department may, for a licensee who has a medical disability or illness, grant a waiver of the

continuing education requirements for a specific period of time or may grant the licensee an extension of time in which to fulfill the requirements.

Sec. 21. (*Effective from passage*) (a) There is established a task force to examine the feasibility of developing a physician relicensing examination. The task force shall consider and report its findings on: (1) Whether a periodic test for relicensing to determine an acceptable level of clinical competence, skills and knowledge would benefit public safety and health; (2) the appropriateness of such a test for all physicians or classes of specialists; (3) how such a test would be administered; (4) at what time intervals in a physician's career such a test should be administered; (5) what type of preparation for a test would be necessary and could be made available to physicians; (6) the consequences of failing the test and how many times a physician would be allowed to retake it; and (7) the costs of such a relicensing process.

(b) The task force shall consist of the following members:

(1) Four licensed physicians, two to be appointed by the speaker of the House of Representatives and two to be appointed by the president pro tempore of the Senate;

(2) Four members of the teaching staff of a medical school, two to be appointed by the majority leader of the House of Representatives and two to be appointed by the majority leader of the Senate;

(3) Two members of the public, one to be appointed by the minority leader of the House of Representatives and one to be appointed by the minority leader of the Senate; and

(4) The Commissioner of Public Health, or the commissioner's designee.

(c) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force which shall be held no later than sixty days after the effective date of this section.

(e) Not later than January 5, 2005, the task force shall submit a report of its findings and recommendations regarding a physician relicensing examination to the joint standing committees of the General Assembly having cognizance of matters relating to public health, judiciary and insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 5, 2005, whichever is earlier.

Sec. 22. (*Effective from passage*) Sections 38a-32 to 38a-36, inclusive, of the general statutes are repealed.

This act shall take effect as follows:	
Section 1	*from passage*
Sec. 2	*from passage and applicable to actions filed on or after said date*
Sec. 3	*from passage*
Sec. 4	*from passage*
Sec. 5	*from passage*
Sec. 6	*October 1, 2004*
Sec. 7	*from passage*
Sec. 8	*October 1, 2004*
Sec. 9	*October 1, 2004*
Sec. 10	*from passage*
Sec. 11	*from passage*
Sec. 12	*from passage*
Sec. 13	*from passage*
Sec. 14	*from passage*
Sec. 15	*from passage*
Sec. 16	*from passage*
Sec. 17	*from passage*
Sec. 18	*from passage*

Sec. 19	*from passage*
Sec. 20	*October 1, 2004*
Sec. 21	*from passage*
Sec. 22	*from passage*

Statement of Legislative Commissioners:
In section 8, "reissue" was changed to "renew" for consistency with the style of the general statutes.

PRI *Joint Favorable Subst.-LCO*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 05 $	FY 06 $
Insurance Dept.	IF - Revenue Gain	Minimal	Minimal
Judicial Dept.	GF - Cost	Minimal	Minimal
Public Health, Dept.	GF - Cost	827,980	767,460
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	136,680	323,510

Note: IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

This bill makes various changes related to medical malpractice reform. Fiscal impacts are as follows:

Section 1 changes the rate of interest applied to offers of judgment made by plaintiffs after the effective date of the bill.[1] Specifically, it pegs the interest rate applicable to offers of judgment at two percentage points above the weekly, average five-year constant maturity yield of United States Treasury Securities. This would effectively reduce the rate of interest on offers of judgment from 12 per cent under current law, to 5 per cent, although that difference would diminish as US Treasury Securities yields and interest rates rise. This change is not expected to significantly lengthen the period of time it takes to dispose of civil cases on a system wide basis such that additional appropriations would be required. Consequently, there is no fiscal impact to the Judicial Department.

Section 2 requires a plaintiff or plaintiff's attorney to file a written

[1] Interest is added to a plaintiff's verdict if the amount of the verdict is equal to or greater than a previous offer by the plaintiff to settle the case. The intent of this provision is to encourage pre-trial settlements by penalizing a party that fails to accept a reasonable offer of settlement.

opinion by a similar health care provider in order to initiate a medical malpractice action. This additional requirement could reduce the number of medical malpractice cases brought before the Superior Court, and thereby decrease the workload of the Civil Division. Any such change would be small relative to the overall caseload since medical malpractice cases comprise less than one per cent of total civil cases added each year.[2] Consequently, there is no fiscal impact.

Section 3 requires a claimant to send a written notice to the health care provider alleged to have caused injury through negligence at least thirty days prior to filing a civil action. It also permits either a claimant or health care provider to request non-binding, pre-suit mediation lasting up to 120 days. An average of 375 medical malpractice cases have been filed with the Superior Court in each of the last five (complete) fiscal years. Although the number of civil cases filed could decrease as a result of pre-suit mediation, it is anticipated that the changes in this section will result in a net workload increase to the Judicial Department by expanding its formal involvement in these civil matters. Such an increase could be accommodated without additional appropriations.

Section 4 prohibits claimants from waiving the contingency fee limits in place under current law. This change is not expected to substantially alter the number of civil cases filed and, thus, there is no related fiscal impact to the Judicial Department.

Section 5 establishes a Task Force on Medical Malpractice Litigation Alternatives and requires it to report its findings no later than January 5, 2005. It is anticipated that representatives of the Departments of Insurance and Public Health and the Judicial Branch will be able to participate within their respective agency's anticipated budgetary resources. It is anticipated that members of the Task Force will not be entitled to reimbursement for expenses.

[2] In FY 03, there were 52,308 civil cases added: 383 of which were medical malpractice.

Section 6 requires medical malpractice insurers to gain rate approval from the commissioner before the effective date of the rate change under certain circumstances. This does not result in a fiscal impact.

Section 7 requires the Insurance Commissioner to create and maintain an information database. The department already collects much of the information that the bill requires. This does not result in a fiscal impact.

Sections 8 & 9 require that captive insurers submit an application and a nonrefundable fee of $175 to the Insurance Commissioner in order to obtain a certificate of authority. Furthermore, the captive insurer must pay all expenses incurred as a result of filing the application. Currently, it is unknown how many captive insurers are in the state, as it is not a regulated industry. The bill also authorizes the commissioner, upon determination, to impose a civil penalty, with a maximum fine of $10,000. This will result in a minimal revenue gain.

Sections 10 & 12 require the DPH to adopt regulations, by December 31, 2004, setting forth (1) guidelines for screening complaints to determine which will be investigated, (2) a prioritization system for the conduct of investigations, (3) guidelines for determining when an investigation should be broadened beyond the initial complaint, and (4) a list of factors that may be used to identify doctors who may not be performing effectively and require further investigation. On and after December 31, 2004, the agency must conduct any review of a malpractice award or settlement in accordance with the adopted guidelines. An annual average of 496 complaints and malpractice payment notices were received by the Department over the 1999 – 2002 time period. As stated in the December 18, 2003 Findings and Recommendations of the Legislative Program Review and Investigation's Committee's report on Medical Malpractice Insurance Rates, the agency's "Practitioner Investigations Unit has nine investigators to review and investigate about 400 cases and complaints at any given point in time."

Section 11 requires the department to present to the Connecticut Medical Examining Board (CMEB) findings of no probable cause and allows the CMEB to review each such recommended closure and request further information or a reconsideration of such finding. This is anticipated to result in additional investigations being conducted by DPH staff. The agency dismisses about 240 cases each year concerning physicians following an investigation.

The DPH will incur FY 05 costs of $489,430 to comply with provisions in **Sections 10 – 12.** This reflects the full-year salaries of: one Physician (at $142,000 annually), one Supervising Nurse Consultant (at $77,400 annually), one Health Program Associate (at $55,280 annually), one Nurse Consultant (at $66,640 annually), one half-time Office Assistant (at an annual salary of $17,435), and one half-time Systems Developer (at $31,320 annually). Also included is three-quarter year support for one Health Program Associate and one Nurse Consultant and one-time equipment costs of $8,000. In FY 06 this cost will increase to $511,910 as the positions are annualized. DPH costs will be supplemented by fringe benefit costs of $97,400 in FY 05 and $234,560 in FY 06. The additional positions will be required to develop regulations, conduct additional investigations as well as investigations of a broader scope than currently performed.

The CMEB is comprised of volunteers who are not compensated for their time. Therefore, no state cost will result from their increased workload due to implementation of **Section 11.**

Section 13 requires the DPH to include additional information related to medical malpractice investigations in its annual report to the General Assembly. The department will incur FY 05 costs of $92,940 to support the salary of one half-time Office Assistant (at an annual salary of $17,435) needed to enter data not presently collected and/or entered into the agency's database, one-time associated equipment costs of $3,000, and costs of one-time data processing services (approximately $72,500) needed to revise the agency's computer database and develop reporting tools. In FY 06 this cost will fall to

$17,440, as the consultant services will no longer be required. DPH costs will be supplemented by fringe benefit costs of $3,530 in FY 05 and $8,000 in FY 06.

Section 14 establishes a Task Force to assist the Medical Examining Board in developing disciplinary guidelines and requires it to report its findings no later than January 5, 2005. It is anticipated that representatives of the Department Public Health will be able to participate within the agency's anticipated budgetary resources. It is anticipated that members of the Task Force will not be entitled to reimbursement for expenses.

Section 15 requires DPH to notify parties who have filed a petition questioning a physician's ability to practice, or the person's legal representative, when the Medical Examining Board has accepted the DPH's recommendation of a finding of no probable cause. The department would also be responsible for providing this same party with the reason for such finding and, if available, a consultant's review. The DPH would incur minimal costs, which can be accommodated within the agency's anticipated budgetary resources to comply with this requirement.

Section 16 requires each physician, podiatrist, chiropractor and naturopathic physician to report the name of the insurance company providing his or her professional liability insurance, the policy number, his or her area of specialization and whether he or she is actively involved in patient care. **Section 17** requires the DPH to report, by January 1, 2005 and annually thereafter, on the number of physicians by specialty, those who are actively providing patient care, projections for physician employment, identification of insufficient supply of certain specialists, and identification of barriers to meeting needs for certain specialists. It also requires the agency to compile an assessment of the inventory of practicing physicians by January 1, 2007 and update this report every three years thereafter.

The DPH will incur FY 05 costs of $126,880 to support the salaries of one Health Associate (at an annual salary of $55,280), one Office

Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at an annual salary of $31,320) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and perform analysis needed to compile the annual report. Also included in this sum are one-time costs for equipment ($4,000), and reprinting the physician renewal card ($1,500). In FY 06 this cost will fall to $121,380 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of $24,560 in FY 05 and $55,620 in FY 06.

Section 18 requires the clerk of the superior court to mail a copy of any medical malpractice complaint filed with the court against a physician, osteopathic physician, chiropractor, naturopathic physician, dentist, or psychologist to the DPH within thirty days after filing. Presently claims that do not result in settlements and judgments do not factor into the investigatory function of DPH. However, per **Section 12,** they would be included in the list of factors the department may use to identify physicians for further investigation.

The Judicial Department would incur a minimal cost, less than $1,000 annually, associated with copying and postage.

Section 19 requires DPH to collect information (for purposes of its Physician Profile Database) reflecting disciplinary actions, criminal convictions and malpractice judgments and awards that occurred outside Connecticut. It also requires the agency to regularly compare data in the physician profile database with information contained in the National Practitioner Data Bank.

The DPH will incur FY 05 costs of $118,730 to support the salary of one Health Associate (at an annual salary of $55,280) needed to compile the required information, one-time associated equipment costs of $2,000, and $61,450 in charges for obtaining an annual report from the National Practitioner Data Bank (at a cost of $4.25 each) for an estimated 14,459 physicians. In FY 06 this cost will fall to $116,730 as one-time equipment costs will not recur. DPH costs will be

supplemented by fringe benefit costs of $11,190 in FY 05 and $25,330 in FY 06.

Section 20 establishes continuing education requirements for certain physicians. The DPH will incur minimal costs, which can be accommodated within its anticipated budgetary resources, to approve continuing education courses and grant waivers as authorized in the bill.

Section 21 establishes a Task Force to examine the feasibility of developing a physician re-licensing examination and requires it to report its findings no later than January 5, 2005. It is anticipated that representatives of the Department Public Health will be able to participate within the agency's anticipated budgetary resources. It is anticipated that members of the Task Force will not be entitled to reimbursement for expenses.

Section 22 repeals the authorizing statute for the Medical Malpractice Screening Panel. No fiscal impact is associated with this change.

OLR Bill Analysis
SB 141

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAL MALPRACTICE INSURANCE RATES

SUMMARY:
This bill makes numerous changes to the laws dealing with civil litigation; insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

Civil Litigation

The bill reduces the interest rate that courts must add to judgments that exceed the plaintiff's offer to settle a lawsuit (called an offer of judgment), from 12% per year to 2% above the weekly average five-year yield of U.S. Treasury Securities. The bill also requires plaintiffs to authorize defendants to get copies of their medical records at least 60 days before they file an offer of judgment. These changes apply to any lawsuit seeking damages, not just medical malpractice lawsuits.

The bill mandates as a condition of filing a medical malpractice lawsuit that the plaintiff or his attorney obtain a signed opinion from a "similar health care provider" that there appears to be evidence of medical negligence. The opinion must be attached to the plaintiff's (or his attorney's) certificate that must be filed with the court along with the complaint or initial pleading that he has a good faith belief medical negligence occurred in his treatment.

The bill establishes a mandatory mediation process for medical malpractice cases if either the plaintiff or defendant asks for it. The mediation must be conducted by a Superior Court judge or two attorneys who practice in the medical malpractice field. One must primarily represent plaintiffs, the other defendants.

The bill specifies that a plaintiff may not waive the mandatory attorney fee schedule that applies to any lawsuit involving a contingency fee arrangement.

The bill establishes a task force on medical malpractice litigation alternatives to examine the feasibility of developing alternatives to the current litigation system.

Insurance Regulation and Oversight

The bill requires

1. the prior approval of medical malpractice insurance rates by the insurance commissioner if there is a noncompetitive market or an insurance carrier asks for an increase or decrease of at least 15%;
2. the commissioner to maintain a database containing information about the medical malpractice insurance market; and
3. captive insurers to receive a certificate of authority from the commissioner after providing certain information to her. The bill establishes a $175 application fee for a certificate.

Regulation, Oversight, and Discipline of Medical Providers §10

The bill

1. requires that, beginning December 31, 2004, DPH's review of malpractice awards and settlements must be conducted in accordance with written guidelines the department develops to determine the basis for such further investigation or disciplinary action;
2. requires the Medical Examining Board to review each recommendation DPH makes to close an investigation into a doctor's ability to practice medicine because it finds no probable cause to believe the doctor violated existing standards;
3. requires DPH to adopt regulations that include (a) guidelines for screening complaints against physicians, (b) a prioritization system for conducting investigations to ensure prompt action, (c) guidelines for broadening the scope of investigations, and (d) a list of factors DPH may use to identify physicians who should be subject to further investigation;
4. requires DPH to include additional information about complaint investigations in the annual reports it must already annually file with the governor and Public Health Committee;
5. establishes a task force to assist the Medical Examining Board in developing guidelines for use in the physician disciplinary process;
6. requires DPH to specify why a complaint against a doctor resulted

in a finding of no probable cause;
7. requires physicians annually to provide to DPH the name of their malpractice insurance carriers, their insurance policy numbers, their area of specialization, and whether they are actively involved in patient care;
8. requires DPH to report annually to the legislature the number of physicians by specialty who are actively involved in patient care and every three years on various trends by physician specialty;
9. requires the Judicial Branch to notify DPH of all medical malpractice lawsuits filed indicating all licensed physicians, natureopaths, chiropractors, dentists, and psychiatrists named in the suit and requires DPH to review these claims to determine whether it should investigate;
10. requires DPH to include in the public physician profile certain additional information concerning out-of-state disciplinary actions, criminal convictions and court judgments, arbitration awards, and settlements;
11. requires a minimum of 40 hours of continuing education every two years for all licensed doctors;
12. establishes a task force to examine the feasibility of developing a physician relicensing examination; and
13. eliminates the voluntary medical malpractice screening panel.

EFFECTIVE DATE: Upon passage, except the provisions dealing with prior rate approval, captive insurers, and physician continuing education take effect October 1, 2004.

OFFER OF JUDGMENT—SECTION 1

Under current law, the plaintiff in a medical malpractice lawsuit may not later than 30 days before trial, file a written "offer of judgment" with the court clerk offering to settle the claim for a specific amount.

The bill requires that at least 60 days before filing an offer of judgment the plaintiff or his attorney must provide the defendants with (1) written authorizations, in a form that complies with applicable state and federal laws, for the release of all medical records of all health care providers treating the plaintiff's injuries, including all records of all health care providers that rendered treatment before and after he was injured for any conditions that were similar or related to such injuries and (2) the names of all experts who will testify on the plaintiff's behalf concerning the prevailing professional standard of care for a health

care provider.

Under current law, after a plaintiff wins an award at trial the court must examine the record to determine whether the plaintiff made an offer of judgment that the defendant failed to accept. If the court determines that the plaintiff has recovered an amount equal to or greater than the plaintiff's offer of judgment, the court must add 12% annual interest.

The bill imposes an adjustable interest rate for offers of judgment filed after its effective date. Specifically, it requires the court to add interest at an annual rate of two percentage points above the weekly average five-year constant maturity yield of U.S. Treasury securities, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the beginning of each year for which interest is owed.

Under current law, unchanged by the bill, the interest must be computed from the date the complaint was filed with the court if the offer of judgment was filed not later than 18 months from that date. If the offer was filed more than 18 months from the date of filing, the interest must be computed from the date the offer was filed.

GOOD FAITH CERTIFICATE—SECTION 2

Under current law, no medical malpractice lawsuit may be filed unless the attorney or claimant has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that negligence occurred in the claimant's care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant to the effect that grounds exist for an action against each named defendant.

Current law allows good faith to be shown to exist if the plaintiff or his attorney has received a written opinion from a similar health care provider as defined by law, that there appears to be evidence of medical negligence (see BACKGROUND). The law allows the court to consider other factors to determine whether good faith existed.

The bill instead requires that, for lawsuits filed after it becomes law, to show the existence of such good faith, the claimant or his attorney must obtain a written opinion that there appears to be evidence of

medical negligence. The bill requires that (1) the written opinion contain the name and qualifications of, and be signed by, a similar health care provider and (2) the claimant or his attorney must attach the opinion to the certificate. It requires the court to seal such written opinion and, not later than 30 days after, determine if the health care provider who signed the opinion qualifies as a similar health care provider, as defined by law.

Under the bill, if the court determines that the health care provider who signed the written opinion does not qualify as a similar health care provider it must notify the claimant or his attorney and permit him to submit another written opinion within 30 days after receiving the notice.

Penalties for Lack of Good Faith

Under current law, unchanged by the bill, in addition to the written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines that the certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court must sanction the person who signed the certificate or a represented party, or both. The sanction may include an order to pay the other party or parties the amount of the reasonable expenses he incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney, submitted the certificate.

MEDIATION—SECTION 3

The bill requires that at least 30 days before filing a medical malpractice lawsuit the claimant must send a written notice to the defendant that contains a brief description of the claim and a certificate of good faith. Sending this notice tolls the statute of limitations until 30 days after the date the notice was sent or, if a request for mediation is made, until 30 days after the date the mediation is completed. This tolling period is in addition to other tolling periods.

Either the claimant or the defendant may contact the Office of the Chief Court Administrator to request non-binding, pre-suit mediation not later than 30 days after the sending the notice. If any party requests

mediation, all parties must participate.

The chief court administrator may assign a Superior Court judge to act as a mediator or assign two attorneys admitted to practice in this state to act as mediators. One attorney must have a practice that consists primarily of representing plaintiffs in medical malpractice actions; the other must primarily represent defendants. Any attorney admitted to practice in this state who is willing and able to act as a mediator may submit his or her name to the chief court administrator for approval and placement on a list of available mediators. Attorneys who act as mediators are not compensated.

A party must provide copies of any relevant medical records within 30 days after receiving the written request of another party.

The bill specifies that the mediation process is deemed to be settlement negotiations for evidentiary and confidentiality purposes. Any mediator findings or recommendations are confidential and not admissible in any court proceedings.

The bill requires completion of the mediation process within 120 days after the request for mediation is made. The mediator or mediators must provide written notice of completion to the parties for purposes of computing the applicable statute of limitation limitations period.

ATTORNEY FEES— SECTION 4

The bill prohibits claimants from waiving the contingency fee limits contained in current law. This prohibition applies to all contingency fee arrangements, not just those involving medical malpractice cases. (Under a contingency fee arrangement, the attorney's compensation is limited to a percentage of the settlement or award.)

Current law establishes a sliding scale on contingency fees attorneys may charge clients in certain cases, including medical malpractice. This law establishes an upper limit on contingency fees attorneys may collect from their clients based on the amount of the settlement or judgment. It allows (1) 33 and 1/3% of the first $ 300,000, (2) 25% of the next $300,000, (3) 20% of the next $300,000, (4) 15% of the next $300,000 and (5) 10% of amounts exceeding $1,250,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not

just to medical malpractice cases.

TASK FORCE—SECTION 5

The bill establishes a 13-member task force on medical malpractice litigation alternatives to examine the feasibility of developing systemic alternatives to the current personal injury litigation system. The examination must include, but not be limited to, consideration of an enterprise liability system and a no-fault system for resolving medical malpractice claims.

The task force is composed of the following members:

1. The public health and insurance commissioners, or their designees;
2. one judge with experience in personal injury trials, appointed by the House Speaker;
3. one person with experience in alternative dispute resolution mechanisms, appointed by the Senate president pro tempore,
4. one law professor with experience teaching tort law, appointed by the House minority leader;
5. one law professor with experience teaching health care law, appointed by the Senate minority leader;
6. one attorney with experience representing plaintiffs in personal injury litigation, appointed by the Judiciary Committee co-chairpersons;
7. one attorney with experience representing defendants in personal injury litigation, appointed by the Judiciary Committee ranking members;
8. one representative of the insurance industry with experience writing medical malpractice insurance, appointed by the Insurance Committee's co-chairpersons;
9. one actuary with experience in medical malpractice insurance, appointed by the Insurance Committee's ranking members;
10. one representative of a trade organization representing physicians, appointed by the Public Health Committee co-chairpersons;
11. one representative of a trade organization representing hospitals, appointed by the Public Health Committee's ranking members; and
12. two members of the public who have been involved in medical malpractice litigation, to be appointed by the governor.

All appointments to the task force must be made within 30 days after the bill becomes law. The appointing authority must fill any vacancy.

The bill requires the speaker of the House and the Senate president pro tempore to select the chairpersons. The chairpersons must schedule the first meeting of the task force, which must be held no later than 60 days after the bill becomes law.

By January 5, 2005, the task force must report its findings and recommendations, including any proposals for legislative changes, to the Judiciary, Public Health and Insurance committees.

The task force must terminate when it submits its report or January 5, 2005, whichever is earlier.

PRIOR RATE APPROVAL—SECTION 6

Under current law, medical malpractice insurers must file rate increases with the insurance commissioner before they become effective, but the rates do not need the commissioner's approval before they become effective. The commissioner can disapprove inadequate or discriminatory rates.

The bill subjects rate increases by medical malpractice insurers for physicians, surgeons, hospitals, and advanced practice registered nurses to the commissioner's prior approval under certain circumstances. Specifically, the bill requires prior rate approval if (1) the commissioner determines the market for such insurance is not competitive or (2) the insurer or its rating organization requests a rate increase or decrease of 15% or more.

The bill requires an insurer or rating organization that files a proposed rate increase during a noncompetitive market to notify each insured subject to the rate increase that one has been requested. The notice must state the percentage by which the insured's current premium will increase if the filing is approved.

The bill requires the commissioner to notify the public of the filing by submitting notice for publication in the Connecticut Law Journal within five business days after the filing date. The notice must indicate that the commissioner must accept public comment for 30 days after the date it is published.

The filing is deemed approved 60 days after the date the notice is

published unless (1) an insured or its representative requests a hearing within 45 days after the notice is published; (2) the commissioner decides to hold a hearing on the filing without such a request; or (3) if no hearing is held, the commissioner disapproves the filing. Any rate filing for which a public hearing has been held is deemed approved not later than 180 days after the date the rate was filed unless the commissioner disapproves the filing. A filing is deemed to meet the requirements of law unless the commissioner disapproves it.

The bill requires that, beginning October 1, 2004 and annually thereafter, the commissioner must determine if a competitive market exists for professional liability insurance for physicians and surgeons, hospitals, or advanced practice registered nurses. The determination applies to each rate filed on or after January first of the next succeeding year. In making this determination, the commissioner must consider relevant tests of competition pertaining to market structure, market performance, and the degree of market competition. These tests may include, but are not limited to,

1. the size and number of insurers actively engaged in the market, both in general and by physician specialty;
2. whether there are enough insurers to provide options to insureds;
3. the degree of market concentration and changes in market concentration over time;
4. the extent to which any insurer or group controls all or a significant portion of the market;
5. the ease of entry into the market; and
6. underwriting restrictions.

The bill authorizes the commissioner to amend the determination of whether a competitive market exists if she finds that the market has changed significantly since the prior determination.

The bill gives any person or insurer aggrieved by the commissioner's determination the right to request a hearing. The commissioner must hold the hearing within 20 days after receiving the request. The commissioner's decision after the hearing may be appealed to Superior Court.

INSURANCE DEPARTMENT DATABASE—SECTION 7

The bill requires the insurance commissioner to maintain a database containing information about the competitiveness of the professional

liability insurance market for medical professionals and entities. The database must be based, in part, on the data collected pursuant to requirements of existing law with respect to rates and policies that insurers must file with the commissioner. This information includes, but is not limited to, premium rates by physician specialty and the number of physicians insured under alternative risk mechanisms. The commissioner may consider any relevant information collected by any other state agency that would assist in determining the degree of competition that exists and how medical professionals and entities are insured.

CAPTIVE INSURERS—SECTIONS 8 AND 9

After September 30, 2004, the bill prohibits captive insurers from insuring a health care provider or entity in this state against liability for medical malpractice unless it has obtained a certificate of authority from the insurance commissioner. No certificate is required for any captive insurer that is licensed in this state to offer such insurance.

A "captive insurer" is an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose exclusive purpose is to insure risks of member organizations and group members and their affiliates.

Application to Insurance Commissioner

The bill requires any captive insurer seeking a certificate of authority to apply to the commissioner on a form she requires, setting forth the line or lines of business that it is seeking authorization to write. The captive insurer must file with the commissioner: (1) a certified copy of its charter or articles of association, (2) evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, (3) a statement of its financial condition and whatever evidence of its correctness as the commissioner requires, and (4) evidence of good management that the commissioner requires.

Each application for a certificate of authority must be accompanied by a nonrefundable fee of $175. The bill also requires that any one filing an application pay all expenses the commissioner incurs in connection with it.

The bill requires the captive insurer to submit evidence of its ability to provide continuous and timely claims settlement. It authorizes the commissioner to issue a certificate of authority permitting such an insurer to do business in this state if the information provided is satisfactory to her, and if all other requirements of law have been complied with. Each certificate expires on the first day of May succeeding the date it is issued, but it may be renewed without any formalities, except as the commissioner requires.

The bill requires the commissioner to adopt regulations specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority must submit and the requirements with which it must comply.

Cause for Revocation

Under the bill, a captive insurer's failure to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause to revoke its authority to write those lines of business.

The bill authorizes the commissioner, after notice and a hearing, to suspend, revoke, or reissue any certificate of authority for cause. She may also impose a fine up to $10,000. The hearings can be held by the commissioner or anyone she designates. The bill mandates that whenever anyone other than the commissioner acts as the hearing officer, he must submit a memorandum of findings and recommendations upon which the commissioner may base a decision. The commissioner may, if she deems it in the public's interest, publish in one or more newspapers of the state a statement that she has suspended or revoked the certificate of authority of any captive insurer to do business in this state.

The bill authorizes any captive insurer aggrieved by the commissioner's action to revoke, suspend, refuse to reissue a certificate of authority, or impose a fine to appeal to the Superior Court. The appeal must be filed in the judicial district of New Britain. The bill specifies that such appeals are privileged in respect to the order of trial assignment.

DPH REVIEW OF MALPRACTICE AWARDS AND SETTLEMENTS—SECTION 10

By law, a licensed health care provider must notify DPH of the terms of any malpractice award or settlement and provide a copy of the award or settlement and the underlying complaint and answer, if any. The department must review all awards and settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. These documents are confidential unless the department determines, following its review, that further investigation or disciplinary action is warranted.

The bill requires that, beginning December 31, 2004, this review must be conducted according to written guidelines DPH develops to determine the basis for further investigation or disciplinary action.

FINDINGS OF NO PROBABLE CAUSE—SECTION 11

Following its investigation, DPH reports its findings to the Medical Examining Board. The bill requires the board to review each recommendation of a finding of no probable cause DPH makes. The board must examine the petition and the entire record of the investigation and may ask DPH for more information or to reconsider its finding. If the board takes no action within 90 days, DPH's finding of no probable cause is considered the final decision by the board.

REGULATIONS—SECTION 12

The bill requires the DPH commissioner by December 31, 2004, to adopt regulations that include: (1) guidelines for screening petitions received to determine which will be investigated (see BACKGROUND); (2) a prioritization system for conducting investigations to ensure prompt action when it appears necessary; (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients and peers; and (4) a list of factors DPH may use to identify physicians who may not be performing effectively and should be the subject of further investigation by the board.

These factors include, but are not limited to, (1) health status or age; (2) number of complaints and malpractice claims, settlements, or judgments; (3) frequent changes in location; (4) adverse actions by

professional organizations, managed care organizations, or licensing boards; (5) failure to recertify in a board specialty; (6) inability to obtain liability insurance in the regular insurance market; and (7) unavailability of peer review. The bill specifies that one factor alone is not a sufficient reason for DPH to investigate.

DPH REPORTS—SECTION 13

By law, DPH must annually file with the governor and Public Health Committee a report of its and the Medical Examining Boards activities. Each report must include the number of petitions received; the number of hearings held on petitions; and, without identifying the particular physician concerned, a brief description of the impairment alleged in each petition or malpractice notification and the actions by the department and the board.

The bill requires that the report also include (1) the number of petitions not investigated and the reasons why; (2) the outcome of any hearings; (3) the timeliness of action taken on petitions; (4) the number of malpractice awards and settlement notifications it received; (5) the number of these notifications with no further action taken and the reasons why; (6) the outcomes for notifications where further action is taken; and (7) without identifying the particular physician concerned, a brief description of the impairment alleged in each notification and the actions the department and the board took about it.

MEDICAL EXAMINING BOARD TASK FORCE—SECTION 14

The bill establishes a task force to assist the Medical Examining Board in developing disciplinary guidelines for use in the physician disciplinary process. The guidelines must include: (1) identification of each type of violation; (2) a minimum and maximum penalty for each type of violation; (3) additional optional conditions that the board may impose for each violation; (4) factors the board must consider in determining if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that, when a deviation from the guidelines occurs, the board must identify the reason. The guidelines must also require that in each final action in the disciplinary process, the board must provide evidence of how it applied the guidelines.

The task force consists of

1. four licensed physicians, one of whom shall be a member of the Medical Examining Board, one each appointed by the House speaker, the Senate president pro tempore, and the House and Senate minority leaders;
2. four public members who have been involved in medical malpractice litigation, one each appointed by the House speaker, the Senate president pro tempore, and the House and Senate minority leaders;
3. one attorney with experience representing plaintiffs in personal injury litigation, appointed by the Judiciary Committee co-chairpersons;
4. one attorney with experience representing defendants in personal injury litigation, appointed by the Judiciary Committee ranking members and
5. the public health commissioner or her designee.

All appointments must be made within 30 days after the bill becomes law.

The speaker and the president pro tempore select the chairpersons, who must schedule the first meeting of the task force, which must be held within 60 days after the bill's effective date.

The task force must submit its report by January 5, 2005 to the Judiciary, Insurance, and Public Health committees. It terminates on the date it submits its report or January 5, 2005, whichever is earlier.

PETITIONS FILED WITH DPH AGAINST DOCTORS—SECTION 15

Anyone who has any information that appears to show that a physician is, or may be, unable to practice medicine with reasonable skill or safety, for any of the reasons listed by law may file a petition with DPH. The state medical society, any county medical society, or any physician or hospital must do so within 30 days of acquiring such information. Any licensed health care facility that terminates or restricts the staff membership or privileges of any physician must, not later than 15 days after the action takes effect, notify DPH.

By law, DPH must investigate each petition to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician. The investigation must be concluded within 18 months from the date the petition is filed. If at any time during the 18-month period, DPH finds no probable cause, the petition and the

entire record of such investigation must remain confidential, unless the physician requests that the petition and record be open. Under the bill, the Medical Examining Board must accept DPH's finding of no probable cause for the finding to remain confidential.

The bill requires DPH to notify the person who filed the petition or his legal representative when the board has accepted DPH's recommendation of a finding of no probable cause and include the reason for such finding. If DPH, as part of its investigation, has obtained a review by a consultant and the board has accepted DPH's recommendation of a finding of no probable cause, the text of the consultant's review must be made available to the person who filed the petition or to his legal representative. The bill requires that the consultant's identity remain confidential.

MANDATORY DISCLOSURE ABOUT INSURANCE—SECTION 16

By law, anyone holding a license to practice medicine, surgery, podiatry, chiropractic, or natureopathy must annually register with DPH and provide his name, residence, and business address. The bill requires that he also provide the name of his malpractice insurance company, his insurance policy number, his area of specialization, whether he is actively involved in patient care, and whatever other information that DPH requests.

NUMBER OF DOCTORS BY SPECIALTY—SECTION 17

By January 1, 2005, DPH must begin reporting annually the number of physicians by specialty who are actively providing patient care. Beginning January 1, 2007, and every third year thereafter, DPH must report the number of practicing physicians. This assessment report must include, but need not be limited to, (1) the number of physicians listed by specialty, (2) the number of physicians actively involved in patient care, (3) projections for physician employment, (4) identification of insufficient supply of certain specialists, and (5) identification of barriers to meeting needs for certain specialists.

Each report must be provided to the Senate and House clerks, the State Librarian, and the Office of Legislative Research.

MALPRACTICE CLAIMS TO DPH FOR REVIEW—SECTION 18

The bill requires the court clerk to mail copies of any medical malpractice claim against physicians, natureopaths, osteopaths, chiropractors, dentists, and psychologists to DPH within 30 days after it is filed in court. The clerk must also indicate all such licensed persons named in the claim.

The bill requires DPH to review these claims to determine whether further investigation or disciplinary action against the providers involved is warranted. The law already requires this when DPH is notified of malpractice awards and settlements

PHYSICIAN PROFILE—SECTION 19

Current law requires DPH, in consultation with the Connecticut Medical Society and the Medical Examining Board, to develop profiles of state-licensed physicians and make them available to the public. The profile must contain information about their education, practice, and certifications; medical malpractice claims and settlements; disciplinary actions; criminal convictions; hospital privileges; and other information.

The bill requires DPH, to the extent available, to include in the profile the following information from other states:

1. any hospital disciplinary actions against the physician that in the past 10 years resulted in the termination or revocation of hospital privileges for a medical disciplinary cause or reason, the resignation from, or nonrenewal of, medical staff membership, or the restriction of hospital privileges taken in lieu of or in settlement of a pending disciplinary case related to medical competence in the hospital;
2. a description of any criminal conviction for a felony within the last 10 years, and
3. all medical malpractice court judgments, malpractice arbitration awards, and settlement against the physician in which a payment was made to a complaining party during the last 10 years.

The bill requires DPH to update regularly the physician profiles by consulting the National Practitioner Data Bank for information on out-of-state medical malpractice court judgments, arbitration awards, and settlements and adverse actions taken in other states against a licensed physician. It also requires DPH to regularly compare information in the physician profiles with information in the national data bank for

consistency and accuracy.

CONTINUING EDUCATION—SECTION 20

The bill requires each licensed physician to complete a minimum of 40 hours of continuing education within the 24-month period following his license renewal. (By law, doctors must renew their license every year.) It must be in areas related to the licensee's practice and consist of courses DPH approved.

Each licensee must obtain a certificate of completion from the provider of the continuing education for all that are successfully completed and must keep it at least six years following the license renewal date for which the activity satisfies the continuing education requirement. The licensee must provide the certificate to DPH whenever it asks for it.

DPH may discipline a licensee who fails to comply with these requirements under its existing disciplinary powers.

The 40-hour continuing education requirement does not apply to a licensee (1) during the two years immediately following his first license renewal; or (2) who has been continuously licensed since October 1, 1979 and is not currently involved in direct patient care. DPH may, for a licensee who has a medical disability or illness, waive the continuing education requirements for a specific period of time or may grant the licensee an extension of time in which to fulfill the requirements.

RELICENSING TASK FORCE—SECTION 21

The bill establishes a task force to examine the feasibility of developing a physician relicensing examination. It must consider and report its findings on: (1) whether a periodic test for relicensing to determine an acceptable level of clinical competence, skills, and knowledge would benefit public safety and health; (2) the appropriateness of such a test for all physicians or classes of specialists; (3) how such a test would be administered; (4) when in a physician's career such a test should be administered; (5) what type of preparation for a test would be necessary and could be made available to physicians; (6) the consequences of failing the test and how many times a physician would be allowed to retake it; and (7) the costs of such a relicensing process.

The task force consists of the following members:
1. four licensed physicians, two appointed by the House speaker and two by the Senate president pro tempore;
2. four members of the teaching staff of a medical school, two each appointed by the House and Senate majority leaders;
3. two public members, one each appointed by the House and Senate minority leaders; and
4. the commissioner of public health, or his designee.

The bill requires that all appointments be made within 30 days after it becomes law. The appointing authority must fill any vacancy. The speaker and the president pro tempore must select the chairpersons from among the task force members. The chairpersons must schedule the first meeting of the task force within 60 days after the bill becomes law.

By January 5, 2005, the task force must submit a report of its findings and recommendations regarding Public Health, Judiciary, and Insurance committees. The task force must terminate on the date that it submits its report, or January 5, 2005, whichever is earlier.

ELIMINATION OF MALPRACTICE SCREENING PANEL—SECTION 22

The bill eliminates the voluntary medical malpractice-screening panel.

Under current law, use of the panel depends on the consent of the parties. In accordance with their mutual agreement, the insurance commissioner or her designee selects panel members from lists of names submitted by the Connecticut State Medical Society and the Connecticut Bar Association. The panel is composed of two doctors and one attorney with trial experience in personal injury cases who acts as chairman. One of the doctors must practice in the same specialty as the defendant. Panel members should not be from communities in which the defendant doctor or the parties' attorneys practice. Panel members are not compensated. The panel holds confidential hearings when and where it decides; transcripts are available at cost to either party.

The panel's conclusion as to liability is set forth in a finding signed by the members and recorded by the insurance commissioner. The panel

does not address the issue of damages. Each party receives a copy of the panel's findings. If a subsequent trial is held, only unanimous findings of the panel are admissible. The court or jury determines the weight assigned to such admissible findings. No member can be compelled to testify.

BACKGROUND

"Similar Health Care Provider"

By law, if the defendant health care provider is not certified by the appropriate American board as being a specialist, is not trained and experienced in a medical specialty, or does not hold himself out as a specialist, a "similar health care provider" is one who: (1) is licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications and (2) is trained and experienced in the same discipline or school of practice. Such training and experience must be a result of active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

If the defendant health care provider is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself out as a specialist, a "similar health care provider" is one who: (1) is trained and experienced in the same specialty and (2) is certified by the appropriate American board in the same specialty. But, if the defendant health care provider is providing treatment or diagnosis for a condition which is not within his specialty, a similar health care provider is a specialist trained in the treatment or diagnosis for that condition.

Complaints Against Doctors Filed with DPH

A person may file a petition against a doctor for the same reasons the Medical Examining Board may discipline a doctor. These include: physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process; emotional disorder or mental illness; abuse or excessive use of drugs or alcohol; illegal, incompetent, or negligent conduct in the practice of medicine; possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; misrepresentation or concealment of a material fact in the obtaining or

reinstatement of a license to practice medicine; failure to adequately supervise a physician assistant; failure to fulfill any obligation resulting from participation in the National Health Service Corps; failure to maintain required professional liability insurance or other indemnity against liability for professional malpractice; failure to provide information DPH requests to complete a health care provider profile; any activity for which accreditation is required by law without appropriate accreditation required; failure to provide evidence of accreditation required by law as requested by DPH; and violation of any law regulating medicine and surgery or any regulation adopted under such laws.

Related Bills

sSB 60 was favorably reported by the Program Review and Investigations Committee on March 3. The bill makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. Tort reform provisions deal with the screening panel, witness immunity, good faith certificate, contingency fees, and the complex litigation docket. Insurance reforms deal with prior rate approval, electronic records, mandates for offering medical malpractice insurance, and captive insurers. The bill also deals with the disciplinary proceedings relating to doctors, data gathering, and presurgical procedures.

sSB 61 was reported by the Program Review and Investigations Committee on March 3. It establishes a fund to reimburse a portion of a malpractice claim, settlement, or judgment that represents the deductible portion applicable to a provider's coverage. It authorizes the insurance commissioner to approve policies that contain deductibles up to $50,0000 for an individual and $100,000 for a hospital.

The bill establishes another fund that pays a portion of a malpractice award or settlement that exceeds certain amounts. The maximum amount the fund may pay per claim is $500,000.

sSB 394 was reported by the Insurance and Real Estate Committee on March 9. The bill makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to sSB 60, except it contains a provision for a fund that sSB 60 does not. Its insurance provisions relate to prior rate approval, captive insurers, data collection, and the requirement for certain

companies to offer malpractice insurance. It establishes surgery protocols, electronic medical records, and procedures for investigation of doctors.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Report
Yea 11 Nay 0